The living situations of orphans in periurban Blantyre, Malawi

To the Editor: Malawi is among the countries in the sub-Saharan region heavily affected by the HIV/AIDS pandemic. At least 10% of the 10 million population is estimated to be HIV-infected.[1] HIV-related illnesses are among the major causes of mortality and morbidity in both children and adults. There has been an increased clinical load from tuberculosis,[2,3] *Pneumocystis carinii* pneumonia,[4] non-typhoid salmonellosis[5] and other infections as a result of HIV/AIDS. HIV prevalence rates in selected groups such as estate workers and antenatal women have exceeded 20% in some areas. The maternal mortality rate, which had been estimated at about 520 deaths per 100 000 live births in 1992, is now put at 1 120 according to the 2000 Malawi Demographic and Health Survey.[6] This sad situation has been explained in part by the HIV/AIDS pandemic.

By 2001 an estimated 14 million children worldwide had lost one or both parents as a result of the HIV/AIDS pandemic.[7] The living situation of orphans in periurban areas of Malawi has not been systematically studied. The present study is an attempt to bridge the paucity of data on the growing social challenge of orphans. A study by Panpanich *et al*.[8] reported that orphans in the community had similar health and nutritional status to non-orphan children. Crampin *et al*.[9] reported similar findings, except that death of an HIV-positive mother was associated with excess mortality compared with death of an HIV-negative mother or death of a father. However these two studies were conducted in rural settings, unlike the present study.

We conducted a cross-sectional survey utilising semi-structured interviewer-administered questionnaires in three villages (Mtambalika, Chakana and Matope) in Ndirande, Blantyre. Ndirande is the most populous township in Malawi, with an estimated population of 150 000. It is a high-density area, with the majority of houses being non-permanent. A total of 157 study participants were recruited from consecutive households that included at least one orphan. These participants were the oldest member of the household at the time of the survey. An orphan was defined as a child with only one parent, i.e. the father or mother had died. Data collected were entered into Excel and analysed using SPSS. Qualitative data were grouped according to themes.[10,11]

Study participants ranged in age from 6 to 84 years (mean 32.3 years, standard deviation (SD) 15.3). The youngest participant was head of the household himself. Forty-one households (26.1%) had one bedroom, 63 (40.1%) had two, and 37 (23.6%) three. The number of occupants per household ranged from 1 to 17. One hundred and six houses (67.5%) were owned by a member of the household, while 51 houses (32.5%) were rented. Thirty-four participants (21.7%) reported that they did not have relatives other than those they were living with, while 123 (78.3%) had relatives elsewhere. However, 42/123 (34.1%) of those with relatives elsewhere reported that they were not visited by their relatives at all. Almost all participants (154, 98.1%) belonged to a religious organisation.

Seventy-seven households had children under the age of 5 years; in 64 of these households (83.1%) all children in that age group had a Road to Health Under Five Card.

Thirty participants (19.1%) reported that household property had been seized by relatives of the deceased. While in many cases the property grabbers were relatives of the deceased father, in some cases maternal relatives had also taken property.

Sources of drinking water were: community tap (N = 100, 63.7%), tap within living compound (N = 50, 31.8%), and stream (N = 17, 10.8%). Some households had multiple sources.

The commonest source of food was small-scale businesses (55.4%), formal employment of member(s) of the household (19.1%), relatives giving them food and/or money (9.2%), and casual labour (8.3%). The type of businesses included selling cooked food, sand and quarry, and illicit beer, such as *kachasu*. Seven female participants spontaneously reported to having exchanged sex for money at some point. Other sources of income included begging, selling household property, and support from community-based organisations (CBOs). Despite the fact that primary education in Malawi is free, money was cited as a common reason why some orphan children were not attending school.

Thirty-one households (19.7%) had at least one member who drank alcohol, while 126 households (80.3%) had no such member. Fewer households (N = 17, 10.8%) had a smoker staying in the house. The usual actions taken when any member of the house fell ill were: (*i*) to visit a health centre or hospital (N = 142, 90.4%); (*ii*) to give medicines at home (N = 53, 33.8%); (*iii*) to tell a neighbour (N = 28, 17.8%); (*iv*) to stay at home and do nothing (N = 13, 8.3%); and (*v*) other (N = 6, 3.8%).

Twenty-eight respondents (17.8%) said that they were stocking some medicines at the time of the study, while 126 (80.3%) had no such stocks and 3 (1.9%) were not sure. The medicines commonly cited were analgesics (aspirin and Panado) and antibiotics (co-trimoxazole and penicillin). One respondent had antihypertensives.

Thirty-four participants (21.7%) reported that they had never received government assistance, while 123 (78.3%) had received assistance at some point. However, when asked whether they thought the government was doing enough for the orphans, 22 (14.0%) thought the government was doing enough, 15 (9.6%) were unsure, and 120 (76.4%) thought the government was not doing enough. It was also reported that in some cases the leadership of CBOs was diverting resources intended for orphans for their own use. It was also reported that CBOs and non-governmental

organisations (NGOs) had difficulty determining who was most in need, as in some cases people who were not so needy had received material support while others in more desperate circumstances had not. Skills training in business and vocational jobs, and access to loans and grants for small-scale businesses were suggested as ways the government and NGOs could better assist households with orphans.

Of particular concern in this study is the finding that up to one-fifth (19.1%) of households experienced property grabbing, a situation where relatives of parents seize property from the surviving family members.[12] Another matter of concern was the spontaneous report by 7 female respondents that they had exchanged sex for money or material goods. We believe that this figure might have been higher had such reports been actively sought — it is likely that such reports were not always volunteered. Also, since the study participant was in each case the most senior member of the household or household head, it is likely that other family members, not in this position, may have exchanged sex for money or other material favours. This has important ramifications with regard to HIV/AIDS.

While the living conditions of orphans in Ndirande may be similar to those of non-orphan children in many respects, the fact that a child has lost one or both parents, that s/he is living in a foster home or alone with other children, and that property may have been taken by relatives is likely to be a source of psychological and social strain. The perception that the government was not doing enough for orphans and that community groups were diverting resources meant for orphans needs to be validated. Future studies should attempt to compare the living situations of orphans with those of non-orphan children.

The fight against AIDS should be geared to address all facets of the problem. Orphans stand out as an obviously vulnerable group. There is a need to anticipate and prevent property being taken from orphans, widows and widowers. This could be done by encouraging people to have a will regardless of HIV status, and by creating and strictly observing pro-orphan legislation. The education system also needs to adapt and be proactive in enrolling and retaining orphans. NGOs working with orphans should be supportive and must learn to listen to orphan families.

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